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Report of the Task Force on Issues of Conscience

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1. Introduction

The choice of medicine as a career, the selection of certain specialties as a focus of that career, and the freedom to practice medicine according to the dictates of one's conscience (instructed by the sacred and certain doctrines of the Church) are at greater risk in the present American society than ever before. The privilege of witnessing as a Catholic physician to the truth of and the binding nature of Magisterial teaching on the licitness of certain health care practices is impaired both by the ruling professional consensus and a developing legal climate. The prevailing influence of third party payers as to which procedures, particularly in the field of reproductive medicine, will be covered and compensated is an impediment to the freedom of the practitioner to select among various therapeutic and diagnostic options.

Historically, the prominent presence of Catholic health care, particularly in community hospitals but also, to a limited extent in tertiary care teaching institutions, has insulated students, residents and practitioners from duress by the public portrayal of Catholic exceptions to certain usual and customary technologies.

Economic threats to the success and even the survival of Catholic hospitals and health centers have put at risk their willingness to claim conscientious abstention from procedures such as contraception, sterilization, abortion or abortion referral and laboratory reproduction. Mergers and acquisitions involving Catholic partners, particularly in small markets, have further eroded public acceptance of the exclusion of certain services previously taken for granted as freely available. In some instances the seeming willingness of Catholic providers to compromise principle for expediency to achieve joint ventures has changed public expectations. A variation among dioceses in policies for rape protocols and so-called "uterine isolation" has led to accusations of "geographical morality" on traditional Catholic bioethical standards.

Highly publicized cases involving conflicts between families and ethics communities on end-of-life issues, such as food and drink for patients in persistent vegetative states, have further portrayed inconsistencies in theological thinking.

The Catholic Medical Association has received numerous reports of pressure and persuasion being exerted on medical students on clerkships and residents in public and private hospitals to conform to institutional policies and "accept their share" of duties requiring performance of participation in activities contrary to Catholic ideology. To a lesser extent Catholic practitioners describe disagreements with chaplains and administrators on conflict cases.

The Catholic Medical Association is dedicated to assisting in individual cases within the limits of our influence. The Catholic Health Association is more involved in institutional cases but should also be willing to advocate for individuals. Both the CMA and the CHA look to the National Council of Catholic Bishops to place these various issues of conscience on their agenda and to take public positions which will be influential in the resolution of policies inimical to Catholic student, resident, and practitioner interests.

This Task Force will compile case reports and will develop approaches for approval by the Catholic Medical Association. Our long-range purpose will be the development of a position paper to be transmitted to the NCCB for further discussion and, hopefully, lobbying on behalf of the preservation of conscientious prerogatives for Catholic health care personnel. We would aim also to coordinate our efforts with the Congregation for Health Care Workers in the Vatican. Members of the Task Force will be chosen for their expertise, interest, and involvement at various levels.

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2. Bias in the Evaluation of Candidates for Admission to Medical Schools

The Catholic Medical Association (CMA) has, on two occasions, undertaken an evaluation of the extent to which pro-life applicants to medical school were subjected to potential discrimination on the basis of their opposition to participation in abortion and/or sterilization.

The first study (*Linacre Quarterly* vol. 43, #1) substantiated, on the basis of questionnaires sent to admission committees of 100 medical schools, that one-third of medical schools regularly asked applicants during their interviews about their position on abortion, another third confirmed that the issue sometimes came up during interviews, and two institutions confirmed that an applicant's opposition to abortion would be construed as a negative factor in the application. Given the highly competitive nature of the application process, the presence of bias or potential bias against pro-life applicants was considered to be a serious impediment to the admission of Catholic and other pro-life students whose performance based on other criteria would be competitive.

Then-Senator Richard Schweiker (R-PA) introduced a bill into the U.S. Senate (S784) that was based on the results of the CMA study and forbade any school or institution receiving federal funds from inquiring into the abortion views of prospective students. Then-Secretary of Health and Human Services (HHS), Joseph Califano conducted a second study, funded by HHS, that confirmed the results of the CMA study. Senator Schweiker's bill was passed but was amended to make discrimination and not inquiry based on abortion a violation of federal law.

A second study by Gunn and Zenner (*Issues in Law and Medicine* 11:363, 1996) indicated that the federal regulation was being observed imperfectly and that the issue of abortion and applicants' religious opinions were in fact being ascertained, either directly or indirectly, and that they were being considered, usually negatively, in the evaluation of candidates at one medical school.

Considering that there are at least six applicants for each available position in medical schools, and considering the exquisitely competitive nature of the application process, the introduction of even subtle negative factors into the evaluation process could be highly obstructive to acceptance.

Beyond the application process for medical school, there is also evidence that applicants to residency training programs are also being discriminated against if they express an unwillingness to participate in abortions (See Charles L. Spooner, Jr., Ph.D., Letter to Mr. Walt Schoendorf, Appendix I, below) from the UCLA obstetrics training

program. There is also evidence of discrimination in physicians' employment (See Memorandum from K. Schlaerth, M.D., Appendix II, below).

The Catholic Medical Association and the Americans United for Life Legal Defense Fund have intervened in the past for students who have been willing to file complaints. It is also necessary for the NCCB to use their prestige and their good office to end this discrimination and to assist students, residents and physicians who are the victims of bias.

Eugene F. Diamond, M.D.

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3. Religious Discrimination in the Selection of Medical Students: A Case Study

by

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In 1978 the Department of Health, Education, and Welfare, responding to congressional concerns,[1] conducted a study to determine whether schools of medicine, nursing, or osteopathy deny admission or otherwise discriminate against any applicant because of the applicant's reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to his or her religious beliefs or moral convictions.[2] Surveys were sent to all schools of medicine, nursing, and osteopathy in the United States, asking whether they discriminated against or denied admission to any of the named groups.[3] In addition, any applicant who had suffered such discrimination was asked to contact the surveyors, and any organization aware of incidents of discrimination was asked to describe details of such incidents.[4]

The questionnaire to the professional schools was organized around four areas of inquiry: (1) Does the medical school have a policy or understanding related to abortion or sterilization? (2) Are applicants ever queried about their views on abortion or sterilization? The school was asked to describe such inquiries. (3) What impact do the views expressed by applicants regarding abortion/sterilization have on an applicant's admission? (4) Are there any complaints by applicants concerning admission because of their views on such topics?[5]

One medical school that responded to this survey answered questions 1, 3 and 4 in the negative.[6] Regarding the second question, it was stated that one faculty member routinely queried applicants about a hypothetical situation in which a fourteen-year-old unmarried Catholic girl requested an abortion. The applicant was asked to discuss the issues presented by this request from the viewpoint of the primary physician. The medical school stated that the purpose of this inquiry was not to determine a point of view, but to evaluate a capacity to identify relevant issues.[7] Whether the Department of Health, Education, and Welfare made any response to this positive answer or what report they made of it to Congress is not known.

This article examines the actual practice of questioning of applicants on abortion and a penumbra of controversial topics in medical school admissions in light of the Department of Health, Education, and Welfare's letter.[8]

Some time after the survey, an opportunity was presented to study the actual admissions process at the school giving the answer described above and to compare it with the information presented to the Department of Health, Education, and Welfare. This particular admissions procedure revolved around a number of factors. College grades (GPA) and the results of the standardized Medical College Admissions Test (MCAT) were considered, particularly in the selection of students to be interviewed by the faculty of the school. Other factors considered included the recommendations submitted by the student's college and the information contained on the application form: questions about the student's demographic data (race, age, birthplace), parents (birthplace, occupation), the high school of graduation, and organizations to which the applicant belonged or other nonacademic activities (church membership was often listed, and some listed anti-abortion activities). In addition, each candidate wrote an essay as part of the application, presenting an account of experiences and motivations leading to the desire to become a physician. On occasion, some applicants mentioned a religious motivation as important in the decision to enter medical school. For medical school acceptance, it was essential that an applicant be selected for an interview. This decision was based largely on an applicant's MCAT and GPA, but

some applicants were invited for other reasons. But however an applicant was selected for an interview, it remained a requirement for admission.[9]

The admissions committee was a decisive entity in the selection of applicants for the entering class, although not all applicants accepted necessarily had the approval of the admissions committee. Since the admissions committee made admissions decisions in most cases, it was a goal that each applicant be interviewed by an admissions committee member, who would then be in the best position to discuss an applicant's file and background. A second interviewer was chosen from faculty volunteers not on the admissions committee. At the committee meetings, each committee member had information from the applications to be discussed, including GPA, MCAT, essay, premedical recommendations, and the written report of the admissions committee member and other faculty interviewer.[10]

The admissions committee member who interviewed the applicant would make a presentation of the applicant's file and a recommendation about suitability for acceptance to medical school. Although each member of the committee had all the information related to a particular applicant, the presentation by the admissions committee member was a critical component in the applicant's consideration. The admissions committee member could, and frequently did, emphasize a particular aspect of the applicant's record or the interview and might add further details from the interview not included in the report. The admissions committee member exercised perhaps the most important function in the evaluation of applicants.[11]

After this initial presentation, each committee member in turn assigned a score to the applicant. A secretary recorded these numbers on a worksheet, averaged them, and assigned an overall score to each applicant. The applicants were then rated by scores, the highest providing the best chance of acceptance.[12]

With the above background in mind, it is possible to review the comments of committee members and faculty interviewers regarding applicants' views on abortion. The cases described are a sampling of the interview reports in a particular admissions year. They should be considered in the light of the school's answer to the Department of Health, Education, and Welfare that candidates did not suffer discrimination as a result of their views on abortion. They should also be analyzed in the context of a state law governing this medical school, which provided that candidates should not be denied admission because of their views on abortion. The names of candidates have been replaced by numbers, and admissions committee members are referenced by letters, which have no relation to the names of the interviewers or committee members. No official minutes were kept of discussions at admissions committee meetings related to applicants, but the chairman of the admissions committee kept a journal with summaries of

some discussions. Records of the interviewers' impressions are correlated with actual admissions committee discussions where available.[13]

Medical School Applicants' Views on Abortion

Case 1: Interview

"In discussing various issues related to medicine – especially ethical and moral issues – I felt her viewpoint was rather narrow or rigid and that she has not thought the issues through very well. She is strongly religious and calls herself a 'Christian.' When I asked her about National Health Insurance, she simply stated that socialized medicine would be a hindrance to the American people – and did not really elaborate on this. When I asked her about her stand on abortion, she simply said that she would never perform one, and would try very hard to talk a prospective patient out of having an abortion, even if this was a rape victim. Although these are sensitive areas, and people's opinions vary a lot, I felt that Ms. 1's answers were preformed rather than logically sound."[14]

Case 2: Interview

"For someone who has had so much experience of a medical person's lifestyle, I found Mr. 2 to be immature and quite rigid in his thinking. He presents as a smiling, clean-cut, well-dressed young man, but he was somewhat at a loss for words, and I could not meaningfully discuss many issues with him. His interests seemed to be exclusively in outdoor sports and in church activities. Although he had taken a good deal of history, government, English, and French in school, I found it hard to discuss current events or controversial topics with him... I was somewhat concerned by Mr. 2's attitude toward religion and medicine. He is a strict Christian who believes in the literal truth of the Bible. He does not believe in the Darwinian theory of evolution, and does not feel that it should be taught in schools and colleges in the way it presently is taught. In hypothetical situations in which he as a doctor might advise a patient about contraception or abortion, Mr. 2 insisted upon taking a highly moralistic stance. For example, he said that when advising a twenty-five-year-old woman about contraception, he would first want her to convince him that her activities were 'moral.' I found this attitude very disturbing."[15]

Case 2: Admissions Committee Discussion

"In the Admissions Committee meeting, Dr. A presented the application of Mr. 2. He expressed reservations because of the candidate's views on evolution but noted that his views might be representative of a segment of the population of Texas. More important, however, Dr. A considered the candidate's views on prescribing birth control pills. The

applicant had stated that he would expect a patient requesting such pills to indicate that she was following certain moral standards. The Chairman again mentioned that these matters could be the subject of court action and that he would be the one called to testify to justify such considerations, and he urged restraint. Dr. B, who also interviewed the candidate, disagreed with Dr. A, and considered him acceptable. Dr. B thought that since the candidate had not been exposed to the material that would be taught in medical school, his views might have been expressed in a way that seemed rigid and perhaps unintelligent but, after being exposed to more knowledge, especially in the biological sciences, that he might handle himself better in such situations. Dr. B saw the candidate's responses to Dr. A as the result of immaturity and thought he would do well in medical school with further seasoning."[16]

Case 3: Interview

"Mr. 3 is very enthusiastic. He's very demonstrative and uses words well. Most of his answers reflected an intelligent understanding of medical issues. God and religion very much influence his life. He is involved with ministers from a theological seminary. In fact, his church, he says, is his major source of social education, since his university is a commuter school, where he feels there is much apathy. Mr. 3 has organized a study group at his home, where he studies 'Bible tapes on the Father, Son, and Holy Ghost and the effect of Satan on the world.' These weekly group meetings, Mr. 3 feels, saved his marriage and give him a code to live by. He feels he would be truly happy if only he could live 100% according to the Bible.

"Mr. 3 said that his religious beliefs would not affect his medical treatment of patients. He spoke of his love of humanity, including fetuses. He said he would refer patients to other doctors when a patient wanted an abortion for birth control purposes. Mr. 3 feels medicine should treat all of the person and pay more attention to the spiritual problems of the patient. Mr. 3 shows potential for a medical career provided he controls his own preconceived attitudes on what will help a patient."[17]

Case3: Admissions Committee Discussion

"In discussing Mr. 3, Dr. C noted the importance of religious belief in the candidate's life. He thought this had been supportive of his achievement. However, Dr. C expressed concern about the applicant's view on evolution because of his view that the Creator had created things in such a way that scientists would be deceived in determining the age of the earth. The Chairman said he thought this was a silly answer. Dr. D asked why candidates were being asked about their religious beliefs. She hadn't heard that religious people had presented a serious problem at school. Only one case (of a student presenting any problem) had been discussed at the committee. She hadn't been asked about her religion when she applied to

medical school and didn't think it was important. Someone mentioned that one religious student had recently withdrawn from school to work principally in religious spheres. The Chairman noted that some pre-professional advisors from two religiously oriented schools had pointed out that the medical school was the only school asking about religious and ethical beliefs. Additionally, the university attorney, in seeking background information on his memo on these areas, had told the chairman that the medical school was the only one of the university's graduate schools asking about religion. At another medical school, some faculty members had been cautioned about holding persons' religious views against them when considering admission."[18]

Case 4: Interview

"What makes this interview difficult is that the student is certainly different from most applicants and is heavy on religion, as expressed numerous times in his essay. Knowing how concerned the committee is about such matters, I questioned him in some detail, but not in any way, I believe, to influence his answers. He does not proselytize and does not even mention it unless specifically asked whether he has 'found God.' He would not hesitate to recommend an abortion or birth control devices to young ladies for whom this would be appropriate. He expresses his religiosity by being patient with people and listening to them, but does not talk of religion unless they bring it up, and then he only mentions how strong his beliefs are. He prays frequently and has fasted on one occasion for three days waiting for a message from God to help him make a difficult decision. He does not hear voices. God answers him by giving him a feeling of what is the right decision. A lot of these matters are reminiscent of other applicants that the committee has turned down, fearing either a psychiatric disorder or a situation where the individual as a medical student or physician will 'moralize' or force religion on a patient when not indicated. While superficially he resembles other applicants who have been objectionable to the committee, on looking more closely, I am sure that he should not be regarded as such. One of the other interviewers may have a different impression."[19]

In the above cases, as full an account as possible was given of the interviewer's written report and the committee discussion to give the flavor of the reports and discussion. Table 1, below, excerpts comments from other reports and discussions:

From the sample cases in Table 1, it appears that the scope of questioning of applicants concerning abortion was wider than portrayed to the Department of Health, Education, and Welfare previously. Several committee members and faculty members sought applicants' views on abortion. Applicants who appeared to be opposed in any way to abortion had their views characterized as "preformed," "downright naïve," "vague," "displaying... considerable rigidity," or "narrow or rigid." The adjectives

chosen are more like judgments on the applicants' views than attempts to characterize their ability to express themselves or evaluate a capacity to identify relevant issues.

TABLE 1: Excerpts of Interviewer and Committee Comments on Abortion

Case #	Interviewer Comment	Committee Comment
5	Vague discussing abortion	Negative view of candidate, who said unlimited abortion could cause things to get out of hand.
6	He has found God but does not hear voices	
7		Negative view of candidate who said she was Catholic and this influenced her view on abortion.
8	Thought on euthanasia and abortion were downright naïve.	
9	Applicant would counsel against abortion and would not refer patient for abortion.	Applicant would dissuade and not refer for abortion.
10	Do not recommend acceptance due to indecisiveness on abortion and pulling the plug.	
11	Displayed rigidity in comparing future of fetus to future of pregnant sixteen-year-old girl.	
12	Rigid, born-again Christian. Has not resolved how abortion will affect medical practice.	
13		Candidate shifted his view on abortion when stressed.

Several of the applicants appeared reluctant to discuss their views, possibly fearing that their opposition to abortion might jeopardize their selection. The students' concern about this was recorded by the dean of admissions after some students approached him on an interview day:

> During the interviews this morning, several students expressed concern that they had been asked such questions about abortion. Ms. 4 indicated she had been asked such questions at another school. Mr. 5 told me that Dr. E asked him how he, as a Catholic, would react to a penniless pregnant teenager who was pregnant. Ms. 6 indicated that her interviewer had asked her how she would react if she were the president of the right-to-life and a pregnant teenager came to her for

an abortion. She responded that she supposed that if she was the president of the right-to-life, she would advise against the abortion.[20]

No extant records contain a case in which an applicant who favored abortion was described in negative terms. If inquiries of this nature were made to evaluate a capacity to identify relevant issues, then a few people favoring abortion might be expected to have problems with their ability to assess complicated problems or identify relevant issues.

Another interesting facet of the cases reported is that evaluation writers and speakers at the committee meetings felt the need to defend against any idea that an applicant opposed to abortion might act in some way on his beliefs. Some stated that, "knowing how concerned the committee is about such matters...," the applicant "... would not hesitate to recommend an abortion or birth control devices to young ladies for whom this would be appropriate." These reassurances support the view of an admissions committee with many members viewing opposition to abortion as an unfavorable factor in medical school acceptance. Additionally, some discussions at admissions committee meetings showed that some members sympathetic to an anti-abortion position recognized the predominant view and opposed it with statements like "... as a Catholic I would agree with the applicant's answer." [The applicant had responded he would not refer a patient who came to him for an abortion to another physician but would attempt to dissuade her from it.]

Medical School Applicants' Views on Religion

In the cases described here, it is apparent that there is an intermingling in committee members' and interviewers' minds of religion and abortion. The Department of Health, Education, and Welfare made no mention of religion in its letter. The school, in its answer, made no mention of its policy on questions about religion. Still, religion and abortion seemed to be interrelated, and it is interesting to examine, in the same way abortion views were examined above, how religious issues were discussed in the interview and admissions process.

Case 14: Interview

"He is a very conservative, and perhaps religious, type of fellow. He is a 'country' type rather than a 'sharp' type."[21]

Case 14: Admissions Committee Discussion

"At the admissions committee meeting of September 18 Dr. F summarized the background of Mr. 14 as a 'religious boy from a small town' and added he would be satisfactory if you liked that type. Dr. G,

voting near the end, indicated he liked religious boys from small towns and gave a score of 4, substantially above the other votes."[22]

Case 15: Interview

"He has been involved in some extracurricular activities during college – primarily student government. However, even when in a major role of leadership, the applicant readily admits that he sought not to take a position or argue a stand that disagreed with the administration of his small, very conservative, denominational college. While I am not necessarily in favor of 'rabble-rousers' being admitted to medical school, I would have been more impressed if he had indicated a strong stand for what he and the rest of his student body felt was right rather than passive submission to the administration of his college. This individual has attended a denominational high school and followed suit with a denominational college. My general impression is that he is somewhat parochial and that his ability to cope with the larger issues of our society is limited at best. When asked for his opinion of the Bahke case or Karen Ann Quinlan, he could offer no opinion at all! Summary: A very high MCAT score and an acceptable grade-point average at a small private college indicate that this individual has a good intellectual capacity. However, in most other respects, I found him wanting."[23]

Case 15: Admissions Committee Discussion

"Today's admissions committee was attended by a guest from an undergraduate college. The application of Mr. 15 was presented by Dr. H. He thought the applicant had a limited background and gave a poor interview. He hadn't heard of the Quinlan case, nor had he opposed the administration of his conservative school even though he was active in student leadership. In his written opinion, Dr. H had commented on Mr. 15's attending denominational schools and his viewpoints being 'parochial.' The chairman asked if we weren't being hard on those who attended denominational schools. On the one hand, we faulted the candidate for attending such schools, but at the same time we considered refusing him entrance to a public university where he might broaden his educational experience. Additionally, his selection of this college might be due to the fact that he is the seventh of ten children, and the fact he was offered a scholarship at the college may have been the determinant. Dr. H indicated that his opinion was primarily based on the interview. Some committee members expressed the view that Mr. 15's reluctance to discuss the Quinlan case may have been due to a fear his views might be held against him. Dr. I provided favorable information on the Jesuit school the applicant had attended."[24]

Case 16: Interview

"His religious commitment came through rather strongly on his written part of the application, so this was pursued in some depth. It was pursued in sufficient depth that I am personally satisfied that he is not a born-again Christian, to the extent that he takes a passive predestination attitude toward life with external controls. It does not preclude him from thinking about specific issues."[25]

Case 17: Interview

"... since he is a very religious person and is the son of a minister, he feels that God wants him to become a doctor. I spent much time questioning him about this because I was unclear how much he wanted to be a physician as opposed to his feeling that he should be or was destined to become a physician. I did get a sense that he wanted it for himself but had it sanctioned by a higher authority.

"I did get a sense of some rigidity of thinking on his part and a tendency to be somewhat judgmental about others who are not 'saved,' although his work history indicates that he can and does get along with all types of people from many different backgrounds.

"Although he was mild-mannered and pleasant, I did get the sense of superiority and some arrogance about him.

"My main concern, although not severe enough to completely reject him from a medical education, centered around the possibility of his losing or questioning his faith. I could see an identity crisis and a great deal of personal turmoil being precipitated by a possible loss of his faith, which, at present, seems to be very firm and unshakable. However, under the extraordinary pressures of medical school, would it sustain him? I do not know for sure."[26]

Case 17: Admissions Committee Discussion

"At the admissions committee meeting the application of Mr. 17 was discussed. Ms. J presented his application. She expressed concern about his indication that God had led him in some way to decide to be a physician. She questioned him on this but thought there was no abnormal ideation and that he could perform as a physician. She rated him at 3 (out of 5). Dr. K stated that Dr. L had called him and expressed strong reservations about the candidate. Dr. M noted that fundamentalist types had caused problems in the human sexuality part of the psychiatry course. One person of a fundamentalist outlook (a student at this medical school) had suggested to a Jewish patient that she accept Christ, and this caused a problem. Dr. N [former dean of admissions, chairman of the admissions committee, and supervisor of the present dean of admissions/chairman of

the admissions committee] thought religion should be considered if it interfered with a person's ability to function as a physician. The chairman thought that charismatic formulations were popular among the young in this part of the country. It was not customary in the area he came from (New York), but he thought religious views should not be held against a candidate, nor should the way they are expressed be a bar. Several times at the committee persons had been referred to as 'rigid Baptists,' and the chairman didn't agree with these characterizations. Dr. O strongly defended the candidate and saw his views as quite exemplary."[27]

TABLE 2: Excerpts of Interviewer and Committee Comments on Religion

Case #	Interviewer Comment	Committee Comment
18		Reservations because motivation based on personal relationship to God
19	Very religious and moralistic but not evangelistic	
20	Intense religious life, coy about religion, reminiscent of skilled proselytizers	Wants to be a missionary
21	Mexican-American Catholic, observant, not fanatical	

Like the cases of applicants who were opposed to abortion, cases in which an applicant held a religious commitment displayed several trends. There appeared to be almost a presumption that religious applicants had to be carefully questioned because religious commitment might make them unsuitable for the practice of medicine. If an applicant revealed a religious facet, he might be asked about "hearing voices." A number of the evaluations cited previously represent defenses of religious candidates, trying to show that even though they were religious or appeared to be "born-again Christians," they were not eccentric. In referring to one religious applicant's views, an admissions committee member stated: "A lot of these matters are reminiscent of other applicants that the committee has turned down" (Case 4, Abortion Cases). He sent the applicant for a psychiatric appraisal to show that the applicant was not mentally unbalanced. He concluded his apologetic comment thus: "While superficially he resembles other applicants who have been objectionable to the committee, on looking more closely, I am sure he should not be regarded as such." This conclusion came after he reassured the committee that "[h]e would not hesitate to recommend an abortion or birth control devices to young ladies for whom this would be appropriate."

Dr. D (Case 3, Abortion Cases) objected to asking applicants questions about religion, and other discussions at the committee showed that some committee members were concerned about religious discrimination and objected to it. Pejorative phrases like "rigid Baptist" and "parochial" were used to describe candidates. There was a climate at the admissions committee conducive to subjecting religious applicants to a comprehensive discussion of their views on a variety of topics with an underlying suspicion that they hear voices, want to bring patients to Christ, or believe that psychiatric illness is due to sin. But there was no analogous inquiry of non-religious applicants. All the above factors support a judgment that the admissions process was hostile to students with a religious commitment. The inquiry by the Department of Health, Education, and Welfare did not focus on religious discrimination, yet, as seen above, abortion and religion seemed connected in many faculty members' minds. There was an assumption that a religious applicant would oppose abortion. The committee was assured by interviewers and members that, even though an applicant was religious, he would recommend abortions to "young ladies..." It is fairly clear from the written evaluations, notes from admissions committee meetings, and reaction of the newly appointed dean of admissions and chairman of the admissions committee, who had not been privy to prior admissions process records, that applicants who were opposed to abortion or were religious underwent a heightened scrutiny and were scored lower than other applicants because of their views.

The justifications given by committee members and faculty interviewers and by the former dean of admissions and chairman of the admissions committee showed that what was occurring was not new but sustained a pattern from prior years.

The new dean of admissions and chairman of the committee was clearly uncomfortable with the system as he found it. He protested to his immediate superior, as well as the dean, and sought an opinion from the university attorney. The university attorney replied stating that questioning applicants about abortion or religion would place the university in an untenable position if an applicant were to sue, claiming discrimination because of his views on either matter.

And so abortion and religion were removed as topics for consideration by the admissions committee. Thereafter, no records were kept of applicants' religious views, nor was discussion permitted of them at committee meetings. Of course, bad habits die hard, and even with the new policy there were recrudescences of the prior practices in the following years. Candidates were referred to as a "New York Jew" (the candidate was not from New York), another as displaying "ultra-Christian religiosity." The difference was that the committee, based on the policy adopted,

directed that such interviewers stop being used. This was probably an improvement, but no external mandate of this nature can change the way people feel about certain topics. An old saying is that one should never discuss politics or religion. The fact that they are not polite social topics of discussion does not mean people do not have strong feelings about them. The hope is that the remedy that emerged here did not just drive biases underground. Perhaps the ultimate answer is to try to match interviewer and interviewee of similar sympathies, so that the interview can center on the applicant's suitability to practice medicine and not his or her personal beliefs. The lesson here is that eternal vigilance is the price of fairness as well as liberty.

Conclusions

Based on the report of actual admissions procedures in a subsequent year, some of the answers (submitted in response to the Department of Health, Education, and Welfare's earlier survey of professional schools) would have to be different, and some would remain the same.

1. There was no official or written policy or understanding related to abortion or sterilization. There was, however, what appears to be a consensus among interviewers and committee members that those who opposed either required special questioning about their views. No such questioning was needed of those who supported such views.

2. Applicants were queried about their views on abortion and sterilization, but not just to evaluate a capacity to identify relevant issues. Applicants' viewpoints were described as "downright naïve," or they were found unable to balance properly the value of a fetus against a sixteen-year-old pregnant girl's future. It is pretty clear from the framework of the question that the interviewer held the view that the future of the sixteen-year-old girl was more important than that of the fetus, and the failure of the applicant to so conclude was not a favorable factor.

3. The views of an applicant on abortion or sterilization could have an impact on admission. Since the only time such views were discussed was when the applicant opposed abortion or sterilization, it seems that this point of view had a negative impact.

4. There were complaints in this admissions year by applicants because of their views on such topics. It would be interesting to send a questionnaire to applicants to see how they were treated rather than to canvass medical or other professional schools as to complaints against them. Applicants hoping for medical school acceptance are often reluctant to complain for fear of dashing their chances for acceptance.

Finally, based on the findings here, it can be seen that the survey was too limited. Interviewers and committee members saw abortion in a

constellation of related beliefs that often centered on religious commitment. There seemed to be an overall apprehension about any candidate with strong religious belief. The perception was that such candidates likely would oppose abortion, and when they were critically examined about their beliefs, this amounted to a surrogate interrogation about abortion.

Additionally, the survey did not touch on matters related to euthanasia, what is now termed "futile care," and similar matters. There were interview questions about "the Quinlan case," "euthanasia," "pulling the plug," and the like. And, again, candidates who had reservations about some of these practices underwent further questioning. Often these opinions seemed coupled in interviewers' and committee members' minds with a religious outlook and an opposition to abortion. Any future survey should look into whether or not candidates are expected to hold specific views on these topics and whether one viewpoint is regarded more favorably in admissions decisions.

The 1978 Health, Education, and Welfare survey did not go far enough in the questions it posed, nor did it include the opinions of applicants, who would be better placed to answer its questions. Now another, more comprehensive, governmental survey would be appropriate with a wider scope to respond to the questions left unanswered by the 1978 survey.

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4. Appendix I

Bias in the Selection of Candidates for Residency in Obstetrics

Letter from University of California at Los Angeles, Office of Admissions, School of Medicine, La Jolla, California

July 15, 1977

Mr. Walt Schoendorf
Office of Assemblyman William A. Craven
Room 5175, State Capitol
Sacramento, California 95814

Dear Mr. Schoendorf:

This is in response to your telephone call of yesterday afternoon concerning a definition of the term "therapeutic abortion," and the Department of Obstetrics and Gynecology's policy regarding residency applicants and therapeutic abortions.

The presently accepted formal definition of "therapeutic abortion" is as follows:

> The termination of a pregnancy performed legally before the stage of viability under certain conditions, as when the physical or mental health of the mother is endangered by continuation of the pregnancy.

It is my understanding that during the interview process of prospective resident applicants, the department elicits information concerning their religious or philosophical convictions which might prohibit them from performing therapeutic abortions. During the final selection process, applicants are separated according to their beliefs regarding therapeutic abortion and the top candidate from the non therapeutic abortion applicants would be added and considered with all of the first 25 ranking regular applicants. Following this initial selection, all of the applicants are considered according to their merits and irrespective of their philosophies. Considerable care is taken in explaining this procedure to applicants by the faculty interviewer, and at the signature stage of employment, all residents sign a statement of understanding that some phases of their employment may involve the performance of therapeutic abortions.

I trust this information will assist you in completing your review of this matter.

Sincerely,

Charles L. Spooner, Jr., Ph.D.
Associate Dean for Admissions

CLA/jd

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5. Appendix II

Memorandum from K. Schlaerth, M.D. Regarding Bias in Employment

I'll soon be leaving my position in the Department of Family Medicine at a premier private university medical school in Southern California, in large part because of a weather-beaten couple who came into the clinic early one morning with an urgent request for a common drug used mostly for stomach ailments. Their demands were made loudly and urgently and accompanied by a pathetic tale of bedside vigils with a family member whose illness was potentially life-threatening. Worry had worn the mother to a frazzle, and she'd decided the only solution to the stress in her life was to abort the "accidental pregnancy" she'd carried for over a month and a half. She was obliged with a prescription, from another physician, for a common anti-cancer drug called methotrexate, which she was gravely warned would damage her fetus, making termination mandatory. She must not miss her next appointment for the drug which would complete the work of the first.

I did not give her the second drug, nor did I give her an appointment to get it. Somehow, another physician magically appeared and was most happy to comply with the, by now infuriated, patient's request, probably summoned frantically by the clerk who saw the makings of a conflict of momentous proportions.

After this event, I got to thinking. Abortions were now being done in the back room of our facility, and resident physicians were learning the procedures. I'd brought up the point that abortions sat ill with patients who may be in the very same clinic for infertility problems, and most mothers would not especially like to have their toddlers vaccinated right next door to where kids a year or so younger were being snuffed. My economically based protestations got nowhere.

Though being named teacher of the year two weeks prior by our family medicine residents, and seeing the largest number of patients of all the providers assigned to our clinic, I realized that my economic and teaching attributes paled in importance to the right of the abortionists in our group practice to empty whatever uteruses they pleased, under whatever conditions they pleased. It was time for me to say, with great heaviness of heart, "sayanora."

My story is far from unique. Another physician faced exactly the same situation at the state university which is known as our cross-town rival, and also submitted his resignation rather than work in a clinic where abortion on demand was practiced. Up north in the San Francisco Bay area, a physician who was the mother and sole support of three young children related in a whisper how she would try to talk young girls into avoiding

premarital sex, or into carrying a pregnancy to term, but feared that any open acknowledgment of her pro-life persuasion would mean loss of her job. Nurses and other health care providers who object to abortions are similarly harassed, forced to resign, or ridiculed in many areas of our fair state and nation.

What does this mean for the public? As more and more health care workers who have a life ethic that values each individual are systematically discouraged from practicing their beliefs, and as attrition forced by a hostile workplace depletes their numbers, young doctors and nurses are increasingly taught by those who believe that life has little value when it is not perfect, or is not desired by others. At this time, in Oregon, a law exists which legalizes physician-assisted suicide. A similar bill is under active consideration in the California State Assembly. Already I've had patients who fear that admission to the hospital will put their care in the hands of those who may end their lives if cure doesn't seem possible. Fortunately, at the current time, this possibility is rather remote.

But will that always be the case? In Holland, terminations have increased in number and safeguards have decreased over the years. Damaged newborns are snuffed if their parents consent. Back at Princeton, the new Chair of the Ethics Department actually espouses the killing of babies with major congenital problems. Medicine's philosophy is slowly swinging from allegiance to the individual patient towards duty to the larger community. People believe the world is becoming too crowded. The logical outcome of a simultaneous consideration of these two factors is decreasing attention to the medical needs of patients considered too much of a social burden.

Football season will never be the same again. When I hear the strains of our beloved "Conquest" played by our marching band, decked out in their plumed helmets, as our white mascot gallops proudly around the track, there will be pride in our football warriors, but it will be mixed with sadness. Our Trojan Horse looks beautiful on the outside, but I know that inside our institution, the values of a culture which thinks only of its own convenience supersede those which acknowledge the value of each individual to live his or her life as planned by the Author of all life from the beginning of time.

Katherine Schlaerth, M.D.
e-mail: kschlaer@hsc.usc.edu
pager: 213-307-4157

References

1. Section 7 of the Health Professions Education Amendments of 1977, Pub. L. No. 95-215, Dec. 19, 1977.

2. To the authors' knowledge, the results of this study were not published.

3. A letter was sent to the dean or nursing director of each school of medicine, nursing, and osteopathy by Daniel F. Whiteside, D.D.S., Director of Bureau of Health Manpower, Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration, Hyattsville, Maryland, dated March 28, 1978, [hereinafter Letter].

4. A notice was published in the Federal Register inviting both successful and unsuccessful applicants (including graduates) to send comments describing their experiences in the admissions process regarding the subject of abortion/ sterilization and opinions as to their probable impact on selection.

5. See Letter, *supra*, note 3.

6. This information is derived from documents provided to the authors and retained in their personal files.

7. *Id.*

8. Letter, *supra*, note 3.

9. This is the customary procedure with respect to all medical schools in the United States.

10. This is by and large the method employed by all U.S. medical schools.

11. This is true because, when the admissions committee member presented the application, he could summarize and emphasize certain parts of the information available on the application in ways he thought appropriate. This summary could be challenged, but committee dynamics being what they are, it was an important factor, challenged or unchallenged, in evaluating applicants.

12. Some medical schools have an acceptance/nonacceptance vote and leave it to the dean of admissions to decide on who is offered acceptance. At the school being described in this article, the committee voted a "rank/order" list. Students were then accepted in this rank/order.

13. The reports of the admissions committee members and faculty interviewers were provided to the authors and are quoted below. Also provided were informal notes of admissions committee discussions, and these are quoted to indicate discussions by the

committee. These notes were reportedly prepared shortly after the committee meetings ended. For purposes of readability, the quotations below have been edited, but the meaning has been preserved.

14. These quotations are from admissions committee or faculty members' interview reports, as provided to the authors.

15. *Id*

16. These quotations are from the notes of admissions committee discussion, as provided to the authors.

17. *Supra* note 14.

18. *Supra* note 16.

19. *Supra* note 14.

20. These quotations are from notes made after the conversations with the students summarizing their remarks, as provided to the authors.

21. *Supra* note 14.

22. *Supra* note 16.

23. *Supra* note 14.

24. *Supra* note 16.

25. *Supra* note 14.

26. *Id*

27. *Supra* note 16.

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6. Rights of Conscience

Throughout history, medicine has been considered a vocation worthy of honor. More than just an occupation, the practice of medicine has been regarded as a calling for those privileged to be part of the health care profession.

Traditionally, the goals of medicine have been to prevent illness, restore the patient to health, and alleviate symptoms. The concept of "good medicine" presupposes that medicine is intrinsically ethical because those

who practice medicine endeavor to promote these goals. This time-honored view of medicine contributes to the higher calling of medicine. When an individual is called to the medical profession, he or she brings his or her own conscience, ethics, and religious beliefs to the profession.

Unfortunately, in our modern society the traditional understanding of medicine as an intrinsically ethical practice is being replaced by the more contemporary view of "technocratic medicine." Under this view, medicine is regarded as a morally-neutral and value-free activity, comparable to any other profession such as science, business, or technology.

This paradigm shift is reflected in the doctor-patient relationship. Instead of a protective relationship between doctor and patient, the health care profession has evolved into a vocation driven by market forces. The patient becomes a "client" choosing the "service" he or she wants based on what health care professionals can provide. This fundamentally alters how health care professionals are viewed: instead of providing patient-centered care, services are provided in exchange for payment. We are abandoning the idea of medicine as a vocation and instead turning it into mere consumerism. Now the doctor primarily exists to serve the autonomous patient.

The shift from the traditional view of medicine to the consumer-driven view is evident in the tension between health care providers who desire to follow their consciences and patients who demand services. It can also be seen in numerous court cases and conflicts between health care employees and employers. For example:

- In Florida, a K-Mart pharmacist was dismissed from his job because he refused to fill a prescription for emergency contraceptives. Meanwhile, the Eckerd Corporation fired three pharmacists because they refused to fill a prescription for emergency contraceptives.

- In Illinois, an emergency medical technician lost her job because she refused to help transport a pregnant woman to an abortion clinic since it violated her conscience.

- In Ohio, a pharmacist was fired when she would not dispense birth control pills to a patient.

- A California physician's group has been sued for violating anti-discrimination laws because a doctor refused to artificially inseminate a lesbian – even though the doctor had said from the beginning (with the patient's approval) that she would treat the patient for infertility but she would not artificially inseminate the woman.

Stories like these have become increasingly common in recent years. Many health care professionals are coming under fire by abortion rights activists and others for choosing to take a strong moral stand on practices they cannot, in good conscience, perform.

As United States citizens, refusing to provide services because of religious and moral objections is a right embedded in our God-given and constitutional rights. God has endowed us, in the words of our Founding Fathers, "with certain unalienable rights, that among these are life, *liberty*, and the pursuit of happiness."[1]

These rights are also expressed in our Constitution's Bill of Rights. Most notably, the First Amendment provides us with the freedoms of speech and the free exercise of our religion. Our right to speak freely and express ourselves provides a basis for allowing health care providers to express their consciences. This freedom extends to health care professionals who refuse to provide services which violate the dictates of their consciences.

Those who desire to follow their conscientious convictions in any walk of life, and particularly in the health care profession, should be commended. Instead, health care professionals are often penalized for refusing to participate in procedures that would violate their ethical standards. The moral dilemma they face is difficult: violate their conscience or risk incurring a multitude of other consequences. These consequences can include:

- Monetary damages
- Loss of accreditation
- Loss of government funding for health care institutions
- Ostracism
- Demotion
- Termination of employment

"Rights of conscience" legislation is intended to protect the right of health care providers to refuse to participate in specific, defined procedures to which they have moral or religious objections.

Although the federal government and 46 states have enacted various conscience clauses to protect health care professionals, all of these have limitations that make them incomplete in several areas. Each conscience clause (with the exception of Illinois' comprehensive statute) is deficient in at least one of the following areas:

- Only covers a narrow range of procedures

- Applies to a limited number of health care workers (often excludes pharmacists)

- Only protects against a few types of discrimination (some may protect from civil and criminal liability but not from employer retaliation)

- Often distinguishes between public and private entities

For instance, the federal government protects the rights of federally funded health care providers and institutions that conscientiously object to abortion and sterilization. South Dakota protects the rights of providers who object to assisted suicide, euthanasia, or to dispensing medication that will cause abortion. California protects the rights of providers who conscientiously object to fulfilling the terms of a living will or a decision made according to a durable power of attorney for health care (regarding the withholding or withdrawing of treatment).[2]

Policy Recommendation: Because of the limitations of these statutes, federal and state governments need to enact more comprehensive conscience clause legislation to protect the rights of health care professionals. No one, least of all a health care provider, should be forced to violate his or her conscience by participating in procedures that he or she deems to be harmful or morally wrong. It is for these reasons that we encourage the adoption of comprehensive conscience clause legislation at the state and federal level.

References

1. United States Declaration of Independence, emphasis added.

2. For a complete list, see the Americans United for Life site on Health Care Rights of Conscience: Current State Statutes, http://www.unitedforlife.org/guides/roc/roc_statute_guide.htm.

7. Five Reasons Why Rights of Conscience Must Be Protected

by

Lynn D. Wardle

The author is Professor of Law, J. Reuben Clark Law School, Brigham Young University. The following was presented to the Section on Individual Rights and Liberties at the 2003 annual meeting of the American Bar Association

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Health care providers today find themselves at the vortex of some of society's most controversial moral dilemmas. These include such issues as abortion, assisted reproductive technologies (ART) assisted suicide, "Baby Doe" cases, brain death, cloning, and contraceptives, to mention just a few of the "ABCs" on the growing list of moral issues. There is increasing pressure upon health care providers, both individuals and organizations, to violate or abandon religious and moral beliefs in order to facilitate convenient access to new drugs, procedures, and technologies.

I am going to summarize very briefly five arguments why it is imperative to protect rights of conscience of health care providers. Lawyers interested in protecting basic individual rights and civil liberties should make this cause a top priority.

First, protection of rights of conscience goes to the very core foundation of our nation. The settling of America by many religious communities and individuals seeking freedom of conscience laid the foundation for the rights and structures of the Constitution of the United States which evolved out of those experiences. Recent scholarship clearly shows that the idea of political liberties in general was grounded in protection of rights of religious conscience in particular.

In America in the late eighteenth century, two different views about matters of conscience were competing.[1] One viewed accommodation of religious conscience to be a matter of *toleration* – that is, utilitarianism, neighborliness, the Golden Rule, and good politics. In some of his early writing, Thomas Jefferson took this approach. But he soon adopted the other perspective, espoused by his close ally and friend, James Madison. Madison spoke of matters of conscience and religion not merely as toleration but as fundamental, natural *rights*. It makes a big difference whether respect for another's moral convictions is given simply as a matter of tolerance (to be suspended when outweighed by other considerations), or whether that is a matter of basic human rights. Fortunately, the Founders

ultimately concluded that protection for religious conscience was a matter of fundamental right. Early colonial charters and state constitutions spoke of it as a right, and during the War of Independence, many states and the Continental Congress granted exemptions from conscription to persons with religious scruples against war, such as Quakers and Mennonites. The Virginia Declaration of Rights was initially drafted to guarantee "fullest toleration" of religion; but Madison amended it to read that "all men are entitled to the full and free exercise of [religion] according to the dictates of conscience." Madison's *Memorial and Remonstrance* expressed the language of rights, not toleration: "The equal right of every citizen to the free exercise of his Religion according to the dictates of conscience is held by the same tenure with *all our other rights*."[2] The First Amendment's twin religion clauses were intended to protect religious rights of conscience against coercion – from the government preventing the free exercise of religion or forcing citizens to support an establishment of religion.

Professor Noah Feldman's recent scholarship shows that "by the late eighteenth century it was broadly agreed in the colonies that there was a basic, indeed natural, right called liberty of conscience,"[3] and that "the purpose of non-establishment was to protect the liberty of conscience of religious dissenters from the coercive power of government."[4]

Liberty of conscience is essential to self-government. In his famous *Memorial and Remonstrance* James Madison declared that religious duties "must be left to the conviction and conscience of every man; and it is the right of every man to exercise it as these may dictate."[5] He explained:

> Before any man can be considered as a member of Civil Society, he must be considered as a subject of the Governor of the Universe: And if a member of a Civil Society, who enters into any subordinate Association, must always do it with reservation of his duty to the general authority; much more must every man who becomes a member of any particular Civil Society, do it with a saving of his allegiance to the Universal Sovereign.[6]

Madison clearly understood that if citizens are not loyal to their conscience, their God, and their moral duty as they see it, it is utter, irrational folly to expect them to be loyal to less compelling moral obligations of legal rules, statutes, judicial orders, or the claims of citizenship, civic virtue, or professional ethics. If you demand that a man or woman betray his or her conscience, you have eliminated the only moral basis for the rule of law, for respect for the rights of others, and have destroyed the foundation for all civic virtue which is essential in a republic.

Second, the Supreme Court has declared that the Constitution protects freedom of choice regarding abortion against state law prohibiting or unduly restricting abortion.[7] The Court also has emphasized that this constitutional doctrine does not compel government to support or facilitate abortion.[8] The decisions can be read as neutrality decisions – the state must not use its power to coerce a decision one way or another regarding childbirth or abortion. The government may prefer, persuade, encourage, and promote, but it may not compel conscience.

The private choice to decline to participate in abortion deserves no less protection than the choice to participate in abortion. When overzealous abortion activists try to use the powers of government to compel participation in and payment for and coverage of abortion, to compel hospitals, clinics, provider groups, and health care insurers as well as individuals, to facilitate abortion in spite of conscience, they contradict the very basis for the exercise of the right to choice they claim.

Third, incidents of intolerance for rights of conscience of health providers are also fundamentally inconsistent with the purpose of the dozens of federal and state laws. The federal government and 48 states have enacted laws, generally called "conscience clauses," designed to protect the rights of conscience of health care providers.

The seminal "conscience clause" law applicable to American health providers is the "Church Amendment."[9] It was enacted by Congress in June, 1973, just eight months after two disturbing incidents involving Catholic hospitals in Montana. In November, 1972, a United States District Court in Billings, Montana issued an injunction forbidding the Catholic St. Vincent Hospital to deny the use of its facilities to a physician who wanted to perform a sterilization on a patient there.[10] The district court ruled that the fact that the hospital had received public funds under the federal Hill-Burton Act was alone sufficient to make the hospital a "state actor" for purposes of federal law and to obligate it to allow sterilizations. Another Catholic hospital, Holy Rosary Hospital of Miles City, Montana, was ordered by a state court judge to allow a woman to be sterilized upon the birth of her daughter by Caesarean section because the Catholic hospital was the only medical facility in the immediate area at which the sterilization could be performed.[11]

Senator Frank Church introduced a resolution (later an amendment) declaring "[t]hat it is the policy of the Federal Government, in the administration of all Federal programs, that religious beliefs which proscribe the performance of abortions or sterilization procedures (or limit the circumstances under which they are performed) shall be respected."[12] Senator Church stated:

> Nothing is more fundamental to our national birthright than freedom of religion. Religious belief must remain above the reach of secular authority...
>
> Now is the time to erect the appropriate safeguards against such transgressions... [T]here is nothing in existing law to prevent zealous administrators from requiring the performance of abortion... as a part of their regulations pertaining to federally funded programs.[13]

Thus, the fundamental purpose of the Church Amendment, and the dozens of federal and state conscience laws enacted since then, is to protect the rights of conscience of health care providers – both individuals and organizations – to decline to participate in or facilitate action that would violate their conscience.

Fourth, there seem to be increasing numbers of incidents involving apparent violations of the rights of conscience of individual health care workers in the United States.[14] For example, there have been numerous cases of nurses who have been fired or discriminated against because they declined to facilitate abortions or provide "morning-after pills" due to religious convictions. Five percent (5%) of the nurses sampled in one study thought that their assignment and promotion opportunities may be limited by their moral and religious beliefs about abortion that extrapolates to 50,000 nurses in America.[15] Likewise, many pharmacists report that they have been harassed, threatened, or fired because they refused to dispense, contrary to their moral beliefs, a morning-after type pill that can operate as a contraceptive but also can kill embryos that are up to seven days old.[16] The medical accreditation agency, ACGME, attempted a few years ago to force all OB-GYN residents in all OB-GYN programs to be trained to perform elective abortions.[17]

Organizations that have pro-life principles, including hospitals with religious affiliations, also have come under increasing pressure to compromise or abandon those principles. Some advocates of abortion on demand have become very aggressive in opposing hospital construction, merger, and joint venture plans involving religiously affiliated hospitals if they will not provide access to elective abortion services. They attempt to use government to compel health providers to allow abortion on demand. There even is a website that lists a dozen places where hospital developments (including mergers) involving religious and pro-life organizations have been derailed or prevented.[18]

The Church Amendment adopted 30 years ago, was intended to stop such attacks upon rights of conscience. Yet three decades later, we continue

to see exactly the same kind of incidents that led to enactment of the Church Amendment.

Fifth, to protect individual rights of conscience in the provision of health service but deny protection to collective (entity) forms of individual conduct is rather like arguing that the first amendment protects only individual speech but not speech by organizations or corporations such as broadcasters and publishers, which are collective, institutional efforts.

Conclusion

Thus, efforts to disregard or restrain rights of conscience are fundamentally flawed and endanger our entire structure of constitutional liberties. We must reject such coercion and protect the rights of conscience of all health care providers.

Three final comments. One speaker this morning referred to "government permission" to refuse to provide abortion. That characterization is mistaken. In our country, we do not need government permission to exercise what Jefferson called our "inalienable rights."

Another speaker said the problem results from growth and consolidation of medical services. I agree that consolidation is another problem in medicine, but the pressure on rights of conscience results primarily from another kind of "growth and consolidation." It is growth of the power of the pro-abortion industry. I remember 30 years ago when *Roe v. Wade* was being debated. I was there. The advocates of abortion then just asked for "the right to choose" abortion. Having obtained the right to choose abortion, they have moved on to demand that others must assist, provide, facilitate, even pay for their abortions. They are willing to deny others the right to choose not to participate in abortion. The "growth and consolidation" of the abortion movement has caused the current crisis.

One final word – *Enron*. When you think of what medicine will be when we teach people to disregard their consciences, remember Enron.

References

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2. James Madison, *Memorial and Remonstrance* (Isaiah Thomas 1786) (available in *Everson v. Board of Education*, 330 U.S. 1, 63 (1947)) (emphasis added).

3. Noah Feldman, "The Intellectual Origins of the Establishment Clause," 77 *N.Y.U.L.Rev.* 346, 374 (2002).

4. Feldman, *supra* at 350-51.

5. Id.

6. Madison, *Memorial and Remonstrance*, *supra*.

7. See *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

8. See *Maher v. Roe*, 432 U.S. 464 (1977); *Beal v. Doe*, 432 U.S. 438 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977).

9. 42 U.S.C. § 300a-7 (1991).

10. See *Taylor v. St. Vincent's Hospital*, 369 F. Supp. 948, 950 (D.C. Mont., 1973) (quoting H.R. No. 93-227; 1973 U.S. Code Cong. & Admin. News at 1553), aff'd 523 F.2d 75 (9th Cir. 1975).

11. *Sterilization Upsets Catholic Hospitals: Eliminating Obstetrics Considered*, in Congressional Record - Senate, Feb. 15, 1973, at 4251 (Statement of Sen. Church introducing S.J. Res. 64, including newspaper articles).

12. S.J. Res. 64, Congressional Record - Senate, Feb. 15, 1973, at 4251 (Statement of Sen. Church introducing S.J. Res. 64).

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16. "A Pharmacist's Dilemma," CBS Apr. 3, 2001 at www.cbsnews.com/stories/2001/04/03/eveningnews/main283760.shtml.

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8. Health Care Rights of Conscience Act Model Legislation and Policy Guide

Americans United for Life™, January, 2002

Introduction

This *AUL Model Legislation and Policy Guide* was drafted in response to the inadequate protection of the civil rights of health care providers who conscientiously object to participating in certain controversial health care services. Current Statutes that address this issue are largely inadequate because, for the most part, all that they provide is a right for physicians, nurses, and private hospitals to refuse to participate in performing abortion. Moreover, these Statutes often narrowly construe "participate" to exclude such activities as referral to and payment for the abortion and preparation of the patient prior to the abortion.

A right to conscientiously object must be a comprehensive civil right for any health care provider to refuse to participate in any health care service based on religious or moral convictions. Individuals, and health care providers no less, have a fundamental right to exercise their religious beliefs and conscience.

The goal of the Health Care Providers Rights of Conscience Act is to provide legislators with a comprehensive model from which to work in designing the best legislation for their State. This model bill seeks to protect any individual, including nurses' aides, pharmacists, students, and others, who may be in the situation of having to participate in a health care service to which he or she conscientiously objects, or risk disciplinary action or liability for his or her failure to participate. In addition, the model also protects both private and public health care institutions, including hospitals, pharmacies, and nursing homes. A Health Care Providers Rights of Conscience Act is a good public policy for every State, because it allows individuals to assert their convictions without fear of any adverse action being taken against them.

The AUL Legal Department continually updates and refines this *AUL Model Legislation and Policy Guide*. We therefore encourage you to contact us for the most recent version of the AUL Guide before drafting legislation for your State. You can reach AUL attorneys by contacting our Legislative Program Coordinator at (312) 492-7234, or legislation@unitedforlife.org.

Nikolas T. Nikas, Esq.
General Counsel

I: Health Care Providers Rights of Conscience Act – Model Bill

Section 1. Title

This Act may be known and cited as the "Health Care Providers Rights of Conscience Act."

Section 2. Legislative Findings and Purposes

(a) It is the public policy of [insert State] to respect and protect the fundamental right of conscience of all individuals who provide health care services.

(b) Without comprehensive protection, health care rights of conscience may be violated in various ways, such as harassment, demotion, salary reduction, transfer, termination, loss of staffing privileges, denial of aid or benefits, and refusal to license or refusal to certify.

(c) It is the purpose of this Act to protect as a basic civil right the right of all health care providers, institutions, and payers to decline to counsel, advise, pay for, provide, perform, assist, or participate in providing or performing health care services that violate their consciences. Such health care services may include, but are not limited to, abortion, artificial birth control, artificial insemination, assisted reproduction, human cloning, euthanasia, human embryonic stem cell research, fetal experimentation, physician-assisted suicide, and sterilization.

(d) Accordingly, it is the purpose of this Act to prohibit all forms of discrimination, disqualification, coercion, disability, or liability upon such health care providers, institutions, and payers that decline to perform any health care service that violates their conscience.

Section 3. Definitions

(a) **"Health care service"** means any phase of patient medical care, treatment, or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions.

(b) **"Health care provider"** means any individual who may be asked to participate in any way in a health care service, including, but not limited to:

a physician, physician's assistant, nurse, nurses' aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty, student, or employee, counselor, social worker, or any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, health care services.

(c) **"Health care institution"** means any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing health care services, including but not limited to hospitals, clinics, medical centers, ambulatory surgical centers, private physician's offices, pharmacies, nursing homes, university medical schools and nursing schools, medical training facilities, or other institutions or locations wherein health care services are provided to any person.

(d) **"Health care payer"** means any entity or employer that contracts for, pays for, or arranges for the payment of, in whole or in part, any health care service or product, including, but not limited to health maintenance organizations, health plans, insurance companies, or management services organizations.

(e) **"Employer"** means any individual or entity that pays for or provides health benefits or health insurance coverage as a benefit to its employees, whether through a third party, a health maintenance organization, a program of self insurance, or some other means.

(f) **"Participate"** in a health care service means to counsel, advise, provide, perform, assist in, refer for, admit for purposes of providing, or participate in providing, any health care service or any form of such service.

(g) **"Pay" or "payment"** means pay, contract for, or otherwise arrange for the payment of, in whole or in part.

(h) **"Conscience"** means the religious, moral, or ethical principles held by a health care provider, the health care institution, or health care payer. For purposes of this Act, a health care institution or health care payer's conscience shall be determined by reference to its existing or proposed religious, moral, or ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other relevant documents.

Section 4. Rights of Conscience of Health Care Providers

(a) Rights of Conscience. A health care provider has the right not to participate in, and no health care provider shall be required to participate in a health care service that violates his or her conscience.

(b) Immunity from Liability. No health care provider shall be civilly, criminally, or administratively liable for declining to participate in a health care service that violates his or her conscience.

(c) Discrimination. It shall be unlawful for any person, health care provider, health care institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against any health care provider in any manner based on his or her declining to participate in a health care service that violates his or her conscience. For purposes of this Act, discrimination includes, but is not limited to, termination, transfer, refusal of staff privileges, refusal of board certification, adverse administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award any grant, contract, or other program, refusal to provide residency training opportunities, or any other penalty, disciplinary, or retaliatory action.

Section 5. Rights of Conscience of Health Care Institutions

(a) Rights of Conscience. A health care institution has the right not to participate in, and no health care institution shall be required to participate in, a health care service that violates its conscience.

(b) Immunity from Liability. A health care institution that declines to provide or participate in a health care service that violates its conscience shall not be civilly, criminally, or administratively liable if the institution provides a consent form to be signed by a patient before admission to the institution stating that it reserves the right to decline to provide or participate in health care services that violate its conscience.

(c) Discrimination. It shall be unlawful for any person, public or private institution, or public official to discriminate against any health care institution, or any person, association, corporation, or other entity attempting to establish a new health care institution or operating an existing health care institution, in any manner, including but not limited to, any denial, deprivation, or disqualification with respect to licensure; any

aid assistance, benefit, or privilege, including staff privileges; or any authorization including authorization to create, expand, improve, acquire, or affiliate or merge with any health care institution, because such health care institution, or person, association, or corporation planning, proposing, or operating a health care institution, declines to participate in a health care service which violates the health care institution's conscience.

(d) Denial of Aid or Benefit. It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants, or benefits, or in any other manner to coerce, disqualify, or discriminate against any person, association, corporation, or other entity attempting to establish a new health care institution or operating an existing health care institution because the existing or proposed health care institution declines to participate in a health care service contrary to the health care institution's conscience.

Section 6. Rights of Conscience of Health Care Payers

(a) Rights of Conscience. A health care payer has the right to decline to pay, and no health care payer shall be required to pay or arrange for the payment of any health care service or product that violates its conscience.

(b) Immunity from Liability. No health care payer and no person, association, corporation, or other entity that owns, operates, supervises, or manages a health care payer shall be civilly or criminally liable by reason of the health care payer's declining to pay for or arrange for the payment of any health care service that violates its conscience.

(c) Discrimination. It shall be unlawful for any person, public or private institution, or public official to discriminate against any health care payer, or any person, association, corporation, or other entity (i) attempting to establish a new health care payer or (ii) operating an existing health care payer, in any manner, including but not limited to, any denial, deprivation, or disqualification with respect to licensure, aid, assistance, benefit, privilege, or authorization, including, but not limited to, any authorization to create, expand, improve, acquire, or affiliate or merge with any health care payer, because a health care payer, or a person, association, corporation, or other entity planning, proposing, or operating a health care payer declines to pay for or arrange for the payment of any health care service that violates its conscience.

(d) Denial of Aid or Benefits. It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants, or

benefits, or in any other manner to coerce, disqualify, or discriminate against any health care payer, or any person, association, corporation, or other entity attempting to establish a new health care payer or operating an existing health care payer because the existing or proposed health care payer declines to pay for, or arrange for the payment of, any health care service that is contrary to its conscience.

Section 7. Civil Remedies

(a) A civil action for damages or injunctive relief, or both, may be brought for the violation of any provision of this Act. It shall not be a defense to any claim arising out of the violation of this Act that such violation was necessary to prevent additional burden or expense on any other health care provider, health care institution, individual, or patient.

(b) Damage Remedies. Any individual, association, corporation, entity, or health care institution injured by any public or private individual, association, agency, entity, or corporation by reason of any conduct prohibited by this Act may commence a civil action. Upon finding a violation of this Act, the aggrieved party shall be entitled to recover threefold the actual damages, including pain and suffering, sustained by such individual, association, corporation, entity, or health care institution, the costs of the action, and reasonable attorney's fees; but in no case shall recovery be less than $5,000 for each violation in addition to costs of the action and reasonable attorney's fees. These damage remedies shall be cumulative, and not exclusive of other remedies afforded under any other State or federal law.

(c) Injunctive Remedies. The court in such civil action may award injunctive relief, including but not limited to, ordering reinstatement of a health care provider to his or her prior job position.

Section 8. Severability

The provisions of the Act are declared to be severable, and if any provision, word, phrase, or clause of the Act of the application thereof to any person shall be held invalid, such invalidity shall not affect the validity of the remaining portions of this Act.

Section 9. Effective Date.

This Act takes effect within [insert number of days] of its enactment.

A civil right of conscience must be recognized for all individual and institutional health care providers. Individuals do not lose their right to exercise their religion once they enter the health profession. Today many health care providers, especially pharmacists and medical students, are at risk of having their right of conscience violated. Pharmacists have been fired, harassed, or demoted for refusing to dispense "emergency contraception."

Many States have enacted "conscience clause" legislation that gives private hospitals, nurses, and physicians a right to conscientiously object only to participating in abortion. What is urgently needed are laws that recognize an affirmative civil right for **all** health care providers, including individuals, whether they work for a private or public health care facility, and institutions, whether those institutions are public or private, to refuse to participate in **any** health care service to which they conscientiously object. This affirmative civil right must protect health care providers who conscientiously object from having any adverse action taken against them. Those who do have adverse action taken against them must be able to assert a cause of action for damages and, in some cases, injunctive relief.

In order to fully protect health care providers, this civil right must extend to anyone who may have to participate in any way in a health care service to which they conscientiously object. This civil right must include the whole range of health care providers, including pharmacists, nurses' aides, students, counselors, and insurance carriers, to name a few. Moreover, "health care service" must be defined expansively to include any phase of the health care service to which a conscientious objection has been raised. "Health care service" must include dispensing medication, recommendation or referral of a service, payment for the service, withdrawal of a service, and training in a type of service.

Public hospitals, too, must be able to assert their civil right of conscience. Some have argued that only individuals and private or religious hospitals may have a right of conscience. This is a myth that must be corrected. The United States Supreme Court held in *Harris v. McRae*, 448 U.S. 297 (1980), that the federal government is under no duty to fund abortion except to save the life of the mother. Public hospitals, therefore, have no duty to provide abortion.

Finally, legal recognition of the civil rights of health care providers in no way infringes on the rights of patients or the quality of care that they receive. Patients have a right to receive the health care services they desire but not a right to force someone to provide it to them. Thus, patients' ability to choose is not hampered by this legislation.

Every State needs to uphold a comprehensive civil right of conscience for its health care providers. Those States that have already

enacted "conscience clauses" must evaluate their Statutes and determine whether they are sufficient to meet the needs of all individuals and health care institutions. It is the intent of this *AUL Guide* to provide States with a model for enacting effective legislation to protect the civil rights of health care providers, institutions, and payers.

III: Myths and Facts

• Myth

It is unconstitutional for health care providers to refuse to provide abortion because women have a right to obtain abortion with no undue burden.

Fact

The abortion right announced in *Roe v. Wade*, 410 U.S. 113, (1973) and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) is the right of a woman to choose whether to terminate a pregnancy. Those cases cannot be read to give any patient the authority to violate the fundamental freedom of conscience by forcing a health care provider to perform an abortion or any other controversial procedure.

Thus, laws that protect the civil rights of health care providers do not forbid women from obtaining abortions. They merely protect health care providers from acting contrary to their consciences. In a free society, it is indisputable that the judicially created "abortion right" does not trump the fundamental human right of conscience.

In fact, the Supreme Court has expressly recognized that governments who object to funding abortion cannot be forced to do so. In *Harris v. McRae*, 448 U.S. 297 (1980), the United States Supreme Court ruled that the federal government does not have to fund abortion except to save the life of the mother. Further, in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), the Court upheld a State Statute that prohibited state-run medical centers from providing abortions except to save the life of the woman. Therefore, this legislation is not an undue burden on a woman's right to abortion, because women have a right to choose, but do not have the right to force an individual or institution, including the government, to provide it.

• Myth

This law is unnecessary because our State already has a "conscience clause" law.

Fact

• Only one State (IL) protects the rights of conscience of **all health care providers**, institutions, and payers who refuse to provide any health care service based on a religious or moral objection. Although forty-five other States and the United States have enacted "conscience clause" legislation, these Statutes are inadequate because they protect the right to object to participating in abortion only. Moreover, many of the current Statutes do not protect all health care providers. For example, pharmacists are often excluded from coverage in these Statutes, and are thus forced to provide "emergency contraception" or mifepristone (RU-486) contrary to their religious or moral convictions.

• **Myth**

The law will endanger the lives of patients because it will allow health care providers to decline to provide health care services.

Fact

The Health Care Rights of Conscience Act affirms the need to provide quality care to patients, and this Act does not interfere with existing medical malpractice standards. The Act merely acknowledges that certain demands of patients, usually for procedures that are life destructive and not lifesaving, must not be blindly accommodated to the detriment of the rights of health care providers.

• **Myth**

The number of physicians who provide abortion services are declining due to lack of mandatory abortion training in medical schools. Because this legislation gives medical schools and medical students the right to conscientiously object, it would prevent the need to mandate abortion training.

Fact

There is no need for medical schools to require abortion training, or to force medical students or residents to participate in abortion procedures. The medical training needed to learn how to empty the uterus of its contents is provided by the standard Ob/Gyn training, which includes performing D&C procedures on miscarried pregnancies known as missed abortions. Missed abortion is defined as a first trimester pregnancy where there is unequivocal evidence of a dead fetus on ultrasound or declining HCG levels prior to passage of tissue spontaneously.[1]

In other words, a resident can learn the skills needed to empty the mother's uterus of an unborn child who has died of natural causes, rather than on a live unborn child. Standard Ob/Gyn training also requires

experience with intrauterine fetal death in later pregnancy, which involves removal of a second to third trimester fetus who has died of natural causes. A physician with such training would thus be qualified to perform induced abortion procedures if he or she chose to do so. Forcing medical students to perform induced abortion on living unborn children is both unnecessary and unconscionable.

1. The *Williams Obstetrics* definition of "missed abortion" is "the prolonged retention of a fetus who died during the first half of pregnancy... [and] as the retention of dead products of conception in utero for eight weeks or more." Furthermore *Williams Obstetrics* defines "missed abortion" as a "subgroup" of "spontaneous abortion." *Williams Obstetrics*, 17 ed. At p. 472.

Catholic Medical Association

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